DEPARTMENT OF PUBLIC HEALTH
DIVISION OF HEALTH CARE QUALITY

CONSENT TO PHOTOGRAPH

RESIDENT NAME:	FACILITY:

By this document, I hereby consent to being photographed by State health survey personnel to ensure that the Federal requirements are met and to assist in evaluating the effectiveness and quality of care that I receive from the above-named facility.

I understand that consent for photography is voluntary and none of my rights to confidentiality or privacy are waived by my consent. I have been told and I understand that refusal to consent to being photographed will have no effect on the level or nature of care and services to which I am entitled.

RESIDENT, OR REPRESENTATIVE OF THE RESIDENT, SIGNATURE:	DATE:

NAME OF SURVEYOR OBTAINING CONSENT: